IHA
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Chairman Wally Herger, Subcommittee on Health
United States House Committee on Ways and Means
1102 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Herger and Members of the Committee,

My name is Tom Williams, and I am the President and CEO of the Integrated Healthcare Association (IHA) in Oakland, California (the required contact information is included at the end of this letter). IHA is a non-profit California-wide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care. Our activities include convening all healthcare parties for cross-sector collaboration on health care topics, administering regional and statewide programs, and serving as an incubator for pilot programs and projects.

Thank you for this opportunity to provide input on rewarding quality and efficiency in care delivery for Medicare providers. These comments are informed by IHA's ten-year administration of the California Pay for Performance (P4P) Program, the largest non-government P4P program in the United States. This program spans the state of California, covering 200 physician organizations representing about 30,000 physicians providing care to 10 million commercially insured patients in eight participating health plans.

Measuring and rewarding provider performance is a pivotal component of the solution to the dual problems of high cost and low quality that plague healthcare in America today. IHA's experience shows that quality and cost measurement can be done in a way that engenders physician buy-in to the process and investment in improvement; a 2009 evaluation of the program by researchers from RAND and the University of California, Berkeley found that participating organizations increased their organizational focus on, and support for, quality improvement, and increased both physician-level feedback and accountability for quality and the speed of adoption of health information technology.

Our experience over the past ten years offers key lessons concerning standardized quality metrics; the importance of a balanced, comprehensive measure set; creating incentives large enough to drive physician behavior; and rewarding both high performance and performance improvement. These are outlined below in an effort to help Committee members consider how to best design reimbursement strategies that will reward quality and efficiency by Medicare providers.

Standardized Quality Metrics

Many healthcare providers across the country are already subject to performance measurement and incentives by one or more of their payers. Measurement is a costly undertaking for providers, who must invest in data collection and reporting mechanisms in order to do well. Although measuring the performance of the healthcare system is important in understanding the quality of care delivered, too much measurement distracts from the ultimate goal of measurement – performance improvement.

Using pre-existing, national standardized quality metrics that align with current measurement and reporting programs (or planned programs that will be implemented in Medicare under the *Affordable Care Act*) can help to alleviate the burden of measurement and reporting on providers, and allow them to focus on improving the quality of care delivered.

Aligning quality metrics with existing Medicare programs, such as the Medicare Shared Savings and Pioneer ACO Programs, would have the added advantage of allowing for comparability between Medicare providers in different programs, thus helping to inform future decisions on payment and delivery system reform.

A Robust, Comprehensive Measure Set

Healthcare quality and efficiency are multi-faceted concepts that encompass following evidence-based processes of care, monitoring under-use and over-use of resources, structural measures of provider capacity (e.g. Meaningful Use measures), how patients perceive the quality of care delivered, and ameliorating patient outcomes. Any measurement initiative should include measures in all of these domains in order to give providers, purchasers (in this case Medicare), and consumers a meaningful picture of the overall quality of care delivered.

The California P4P Program's own measure set includes 85 measures in all of these categories, as seen in the accompanying table. These measures were introduced gradually over the life of the program – when measurement began in 2003, the measure set was comprised of only 25 measures. Introducing measures over time gives providers a chance to become comfortable with measurement and the process of improvement.

Table: California P4P Measure Set Expansion, 2003-2011

Measurement Domain	2003	2005	2007	2009	2011
Clinical – Preventive	8	10	12	14	18
Clinical – Chronic	3	9	10	12	17
Clinical – Acute	0	1	1	4	4
Patient Experience	6	7	7	9	9
Meaningful Use of HIT	8	10	19	21	20
Efficiency/Resource Use	0	0	0	16	17
Total	**25**	**37**	**49**	**76**	**85**

The California P4P Program began measuring efficiency and resource use in 2009 with a set of sixteen appropriate resource use measures that focus on overuse and underuse of key healthcare resources (e.g. hospitalization, readmissions, and generic drug use). In 2011, a new measure of Total Cost of Care was introduced that captures the total cost of care – including all covered

professional, pharmacy, and ancillary care – delivered to all patients enrolled in a physician organization on a per-member basis. Program stakeholders, including the physician groups subject to measurement, have embraced these measures as vital to understanding the overall quality of care delivered.

Although measuring efficiency and costs is key to first understanding, and then lowering, the costs of healthcare in this country, cost and resource use measurement is a relatively new frontier in American healthcare, as witnessed by the fact that the National Quality Forum has only recently endorsed resource use and cost measures. Looking at these measures is a good place for Medicare to begin when deciding upon what resource use measures to employ in any payment reform initiative.

Creating Incentives Large Enough to Drive Physician Behavior Changes

In order for incentive programs to drive changes in physician behavior, they must comprise a meaningful percentage of total compensation, generally thought to be around 10%. When the California P4P Program began in 2001, one of its overarching goals was "breakthrough" improvements in California's quality performance. To date, this goal has not been reached in part because performance incentives have made up a relatively small portion – less than 2% - of total physician compensation.

Saving money and improving quality in the Medicare program will require CMS to implement incentives that are large enough to drive changes in provider behavior. Any reform must also be monitored to ensure that the potential negative impacts of performance-based pay (e.g. patient exclusion and "teaching to the test," or focusing on what is measured to the exclusion of other, equally important aspects of care) are minimized.

Rewarding Both High Performance and Performance Improvement

Along with the size of incentives available, how those incentives are structured is also important in driving behavior. Certain payment methodologies are better-suited to driving improved quality across providers, regardless of initial performance, than others. Payments that reward high performance and performance improvement, rather than rewarding based on relative rank, are the most effective at encouraging improvement across the board.

The California P4P Steering Committee has adopted a recommendation that all participating health plans adhere to a standard payment methodology based on CMS' Value Based Purchasing methodology, which scores the performance of each physician organization in two ways: first, based on level of attainment, and second, based on the amount of improvement. The higher score is then used to determine payment amount.

Bringing it All Together: Key Lessons

Our experience over the past ten years offers four key lessons that Committee members must keep in mind when considering how to reward quality and efficiency by Medicare providers:

1. Use pre-existing, standardized quality metrics that align with already-existing performance measurement and reporting programs;

2. The measure set should be comprehensive, and address clinical quality (both process and outcome), appropriate resource use and costs, structural elements of the care setting, and patient experience of care;
3. Quality-based incentives must be substantial enough to drive physicians to deliver higher-quality, lower-cost care; and
4. Payment mechanisms must be designed to reward both high performance and performance improvement.

We applaud the Subcommittee on Health for taking on such an important topic; Medicare spending currently comprises approximately 13% of federal outlays, and bringing this number down is key to the ability to lower federal debt without crowding out equally important federal programs, as well as maintaining the US's competitiveness well into the future.

Sincerely,

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